Germany's Long-Term-Care Insurance: Putting a Social Insurance Model into Practice

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TO AN EVEN GREATER EXTENT THAN MOST industrialized countries, including the United States, Germany faces a tremendous growth of its elderly population. In 1995, Germans 60 years of age and older accounted for 21 percent of the population. This percentage is expected to increase to 36 percent in 2030 (Bundesministerium fuer Arbeit und Sozialordnung 1998a). To handle the anticipated explosion of need for long-term-care services and the financial burden entailed in paying for them, Germany introduced a mandatory long-term-care (LTC) insurance system in 1995 that became fully operational in July, 1996.[1] Not only the elderly but also the entire German population of about 82 million are now protected against much of the financial risk of chronic illness and disability.

The German approach could serve as a useful model for the United States, where the need for LTC insurance and the pros and cons of different LTC concepts have been much debated (Harrington, Cassel, Estes, et al. 1991; Lucas 1996; Wiener and Stevenson 1998). We will therefore describe the broad social insurance framework that contains the new German LTC system, as well as the background and objectives of that

[1]Gesetz zur sozialen Absicherung des Risikos der Pflegebedürftigkeit (Pflege-Versicherungsgesetz-PflegeVG vom 26. Mai 1994), Bundesgesetzblatt. I S. 1014, 2797.

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system. After reviewing its organizational features, including eligibility and covered benefits, we report on the accomplishments of the maturing LTC system after about four years of operation. We also comment on criticisms of the system. We conclude, finally, that the newly introduced German social LTC insurance system could well serve as an example for countries that wish to build their own social LTC insurance systems.

Background and Goals of the New Long-Term-Care Insurance System

The primary goal of the LTC insurance law in Germany is to provide relief from much of the financial burden of long-term disability and illness, thereby complementing the comprehensive medical services financed by the health insurance funds with the newly created coverage for LTC both in the home and in a nursing facility (Kamke 1998). The German government decided to integrate LTC coverage into the social security system, which rests on the principle of social insurance. Thus, the Long-Term Care Insurance Act of 1994 became the fifth building block of the German social insurance system, which began with Bismarck's Health Insurance Act of 1883 and subsequently added statutory accident, pension, and unemployment insurance.

Because the risk of paying for required LTC services usually overtaxes an individual's financial means, the need for these services constitutes one of the typical risks that, according to the principles of the German welfare state, should be covered within the German social insurance system. However, the existing four social insurance systems did not cover LTC services. Before the inception of the new LTC insurance system in Germany, 80 percent of elderly Germans (and/or their families) living in nursing homes could not afford to pay the full fees and charges. These nursing-home residents depended on public assistance and received payments from the community-run social welfare system, which was funded by the German states (*Laender*) and communities. Because communities increasingly complained of escalating deficits as a result of having to make these payments to nursing homes, the need to remedy this problem became compelling.

In addition, more family members were caring informally for relatives who needed LTC services. The situation of these family caregivers worsened from year to year. Because they lacked societal support and

frequently had to stop working, their financial circumstances, and thus their motivation to care for their relatives, steadily deteriorated. Moreover, there were no short-term or part-time nursing-home facilities or home health care agencies to provide some respite from the burdens of caregiving. Informal care givers thus often had to send their ailing relatives into nursing homes sooner than was necessary.

After 20 years of debate, the German government decided in 1991 to design and implement an LTC system. The Parliament discussed three options before approving the third:

1. obligatory private insurance
2. a tax based system
3. social insurance

Alber and Schoelkopf (1999) concluded that the social insurance model was adopted because it was compatible with Germany's cultural values of social responsibility. The model was consistent with existing social insurance coverage for health, accident, pension, and unemployment insurance. The administrative system could be based on the experience of existing health insurance funds. Overall, the new model promised to ease the fiscal burden on individuals and families and on the Laender and to ease the strain on the federal budget that had resulted from the reunification of East and West Germany.

The political support for the social insurance program came from the public, which wanted to avoid dependence on public assistance. Before the new LTC insurance system was introduced, about 80 percent of all nursing-home residents received public assistance payments. In a significant redistribution of funding sources, the new LTC insurance law shifts costs from the local, community-based public assistance system to the state- and federally based social LTC insurance system. At the same time, the LTC insurance funds now assume payment for the LTC services, whereas previously these benefits were covered by the statutory health insurance funds. Thus, the new system also shifts costs from the health insurance funds to the LTC insurance funds, thereby protecting against the need to increase health insurance premiums in order to provide for LTC benefits in the future.

In order to reach agreement on the new system for mandatory LTC insurance, the Laender eliminated one official paid holiday (except in the state of Saxony). Because one paid holiday is equal to about 75 percent of

the employers' LTC contribution, its elimination lightened employers' cost burden for the LTC insurance system. Although the unions were initially reluctant to make this concession, they eventually were convinced to agree to it. This action was unprecedented within the context of Germany's social insurance system because it marked a departure from the 50–50 contribution sharing that generally governed social programs. The employees' contribution of a paid holiday to pay for the employer share of the social insurance reduced the initial employer opposition to the legislation (Alber and Schoelkopf 1999).

The German Social Insurance System

Social insurance in Germany consists of a mandatory transfer payment system, whereby persons currently in the workforce and their employers pay for recipients' insured benefits. Employees and employers make equal contributions for LTC, health, pension, and unemployment insurance, whereas only the employers pay for accident insurance. The Federal Employment Agency is solely responsible for making contributions on behalf of unemployed individuals. Pensioners are required to pay 50 percent of their aggregate contribution (i.e., premiums) for health and LTC insurance, and their pension insurance fund pays for the other half. When an employee's family members are not gainfully employed in the labor force, they are covered without additional charge by the head of household's social health and LTC insurance. Consequently, the insurance contributions for families with one principal breadwinner equal those of single employees within the same income bracket.

This rule can be traced back to a basic German social insurance concept: the "solidarity principle," which stipulates that members of society are responsible for providing adequately for one another's well-being through collective action. Although everyone whose income falls below the threshold "income limit for mandatory health and LTC insurance" (in 1999, this amount was $43,466 gross income per year in western and $36,818 in eastern German states) must belong to the mandatory public system and contribute to it, those with higher incomes have the option either to join the public insurance system or to buy private insurance. The contributions to the system rise to a maximum premium at a rate proportionate to each family's income, so that the contributions for social insurance result in a redistribution of income from the wealthier members of society to those on the lowest end of the income scale.

A similar redistribution occurs as family units with two breadwinners, or those with no children, subsidize families with only one contributing breadwinner. For the public LTC insurance, the maximum aggregate contribution rate in 1999 amounted to the U.S. equivalent of $739 in western and $626 in eastern Germany, which equals, on average, 1.7 percent of each employee's gross income.

Seventy-five percent of the German population fall within that income limit and are therefore required to be members of the social health and LTC insurance systems. Another 13 percent of the population, while legally entitled to join private LTC insurance plans, nevertheless opted to be members of these public insurance systems. The head of a family whose income exceeds the upper threshold would be likely to choose the public insurance system primarily because a single premium would cover the benefits for his or her whole family, in contrast to a private insurance plan, which is entitled to charge a premium for each family member. Altogether, 88 percent of the population belongs to the public LTC insurance plans, either as contributing members (51 million) or as covered family members (21 million). The approximately 10 percent of the population with high incomes and private health insurance is obliged by law to buy private LTC insurance and does not have to contribute to the public LTC insurance system. The remaining 2 percent of the population (including the military) receives free governmental insurance. Thus, all of Germany's 82 million inhabitants are now covered by either social or private LTC insurance.

Table 1 shows the contributions for the five social insurance systems in Germany as a percentage of the employees' gross income. The new LTC insurance system is the least expensive of the social insurance components: contribution rates for employers and employees each come to .85 percent of the employees' gross income (table 1) (Bundesministerium fuer Gesundheit 1998).

Long-Term-Care Infrastructure

Another goal of the LTC insurance law is to promote the creation of a new infrastructure for formal LTC services in Germany, where most patients requiring long-term care are still cared for by relatives. However, shifts in family structure that have led to growing numbers of single-person households, more elderly persons living far away from their relatives, and the desire of the elderly to live independently for as long as possible

TABLE 1
Average Social Insurance Contributions in Germany, 1997[a]

Social insurance type	Percent share of		Total contributions per year ($U.S.)[c]
	Employee[b]	Employer[b]	
Health	6.82	6.82	3,556
Long-term care insurance[d]	*.85*	*.85*	*443*
Unemployment insurance	3.25	3.25	1,695
Pension insurance	10.15	10.15	5,293
Accident insurance	—	~2.50[e]	652
All contributions	*21.07*	*23.57*	*11,638*

[a]Average gross income from employed work in Germany came to $26,072/year in 1997. Average 1997 exchange rate: $1 = 1.73 DM. Deviations in the sums are due to rounding errors.
[b]As percentage of employees' gross income.
[c]Average sum of contributions from employees and employers. Since even pensioners contribute to health and LTC insurance, the actual average contributions of all members of those social insurances are lower.
[d]Sum of contributions of employees and employers came to 1.7% starting on July 1, 1996.
[e]Estimated average percentage: actual amount of contributions to the statutory accident insurance depends on the amount of wages and salaries and the respective hazard level.
Source: Federal Ministry of Health 1998.

result in the need for additional and new types of LTC services (Heinze, Naegele, and Strunck 1996). In the past, the elderly who did not have help from their relatives relied mostly on expensive, but sometimes unnecessary, nursing-home care. Because new services emphasize "assisted living" services instead of nursing homes, the new LTC insurance system creates incentives and provides financing to develop home health care agencies, part-time and short-term institutional care facilities, and assisted-living facilities. Until now, the field of home health services in Germany has been dominated by charitable institutions. To allow for more competition and a relatively free market within this field, the government does not restrict the number of new institutional LTC facilities and licensed home health care agencies, as it does for acute-care hospital and physician supply.

Promoting Home Nursing Care

Despite the newly created availability of professional LTC services, most families with a relative in need of LTC will continue to care for their

family members at home. One reason is that, especially in contrast to the United States, the caregiving potential in German families is still very high (Alber 1992). However, because staying in familiar surroundings is the desire of most people who require assistance with daily activities, the law focuses on providing benefits that improve conditions for home care. In order to support this goal, the designers of the LTC insurance system acknowledged the sometimes enormous burdens that are imposed on informal caregivers by providing them with cash benefits and free LTC training courses and by paying contributions to the statutory pension insurance for nonprofessionals who provide more than 14 hours of home nursing care per week.

Long-Term-Care Insurance Funds

The LTC insurance funds are the responsible bodies on the payer side that provide, among others, the benefits to informal caregivers. Like the German statutory health insurance funds, these LTC insurance funds are self-governing, nonprofit corporate organizations. Employers and employees are equally represented on their boards of directors.

Each of Germany's approximately 500 statutory health insurance funds has its companion LTC insurance fund. Seven associations of social health and LTC insurance funds represent the main classifications of insurance funds (regional, guilds', companies', agricultural, seamen's, miners', and substitute health and long-term care). The large number of health and LTC funds is mainly due to the fact that there are more than 350 small company-run insurance funds. The vast majority of eligible beneficiaries (76 percent) are concentrated in the two associations that incorporate the 18 regional insurance funds and seven federally organized, "substitute" insurance funds. Portability among the different health and LTC insurance funds is guaranteed, and members have been allowed free choice of insurance funds since 1996, which means they can switch to another insurance fund at the beginning of each year. Employees can choose among the various health insurance funds but are assigned to the LTC fund that is associated with their chosen health insurance fund.

The associations of LTC insurance funds, together with the associations of providers of LTC, are by law the leading players in the field of LTC. As a matter of principle, the federal and state governments are

responsible only for oversight of these associations. Decision-making power is vested in these self-administered, nonprofit organizations of providers and payers, which are obligated to regulate the system in accordance with the needs of the public by negotiating and entering into contracts with each other. In contrast to health insurance funds, however, the power of the LTC insurance funds to establish contribution rates for their members and negotiate fees with LTC providers is currently restricted, as both the contribution rate and the global budget for the range of benefits are fixed by governmental regulation.

Thus, the insurance funds are responsible for collecting members' contributions, determining members' eligibility for services, and reimbursing providers for home and institutional care within the limits of their respective budgets. Moreover, the LTC insurance funds have the duty to advise their members on all questions regarding LTC.

The most important task of the seven associations of LTC insurance funds is to negotiate on a regional level with professional home and institutional care providers to establish fee schedules. These negotiations must follow certain rules: Home care providers seek to obtain the best terms for each of the 24 different bundled home LTC service complexes (e.g., hygiene in the morning or evening) that providers and payers have agreed to during their federal contract negotiations. The insurance funds, in turn, try to achieve the lowest possible rate for each of these services. Their goal is to allow their members to buy all necessary services within the prescribed benefit framework so that they do not have to pay for any part of LTC services on their own. The insurance funds also negotiate individual fee schedules for the different care levels with individual institutional care providers. When they are negotiating the terms for nursing care, board, and assisted-living amenities, the different institutions are guaranteed by law to receive performance-related, "fair" (i.e., justifiable and reasonable) payments for services rendered. Again, the LTC insurance funds try to pay the least possible amount for services in order to avoid their members (and the public assistance system) having to pay high out-of-pocket costs, respectively, to augment the LTC insurance coverage. Negotiations are completed each year to establish the rates for the coming year.

Last, but not least, the LTC insurance funds work out measures for quality assurance together with the care providers and are responsible for regularly evaluating the quality of LTC services (see below).

Federal Long-Term-Care Committee

The tasks of quality assurance and evaluation of the LTC insurance system are not solely carried out by the LTC insurance funds. To allow all stakeholders to participate in decisions about LTC, the LTC Insurance Act established an advisory Federal LTC Committee. Its 53 members represent federal, state, and community governments, associations of LTC insurance funds, and associations of ambulatory and institutional care providers. Together, they supervise the development of the new LTC insurance system. Their main task is to counsel the federal government on all questions concerning LTC in Germany and, in general, to improve the quality of LTC by reporting on problems and finding appropriate solutions to them.

Eligibility

Eligibility for the covered services depends on a demonstration of need for LTC. Benefit levels depend on whether a beneficiary requires frequent or substantial help with normal daily activities on a long-term basis—presumably for more than six months. Much effort has been invested in defining the term "need for long-term care assistance" within the law. Apart from defining the long-term "care level" (according to need criteria, which determines LTC payments, as described below), it was necessary to establish the demarcation between the benefits of the sickness funds and those of the LTC insurance funds. The former remain responsible for medical and rehabilitative services. Rules also had to be established to assure that the LTC funds would not be assigned the cost for "hotel services" (i.e., room and board) and for social care.

Care-Level Assignment

To determine whether, and to what extent, a beneficiary requires long-term care, the health insurance fund's medical service departments examine applicants in their homes. In general, four different areas—personal hygiene, eating, mobility, and housekeeping—are taken into account when determining whether a member needs assistance. In order to make the process as uniform as possible, the medical service departments agreed

upon a nationwide standard set of criteria for assessing the level of care on site.

If a member is certified as requiring long-term care, he or she will be assigned to one of the following three care levels in order to determine the appropriate benefits:

1. *Care level I.* Persons at this level have considerable need for care. The member needs help at least once a day with personal hygiene, eating, or with a minimum of two of these types of activity. He or she also needs help several times a week with household chores. The average amount of time an informal caregiver would require to assist the member must be at least 90 minutes every day of the week for basic care and help with household chores. The provider must spend more than 45 minutes of this time providing basic care.
2. *Care level II.* Persons in this category have a severe need for care. The member needs help at least three different times a day with personal hygiene, eating, or getting around, and several times a week with household chores. The provider would spend an average of at least three hours a day, and at least two of these hours must be devoted to basic care.
3. *Care level III.* This category describes an extreme need for care. The member needs round-the-clock help every day. Care requirements at level III add up to at least five hours a day, and at least four of these hours must be spent on basic care (Bundesministerium fuer Arbeit und Sozialordnung 1998b).

If a member's child needs care, the child's care level will reflect how much additional help he or she requires compared with a healthy child of the same age. These care-level assignments dictate how much money the LTC insurance funds provide for home and institutional care. Home care benefits also depend on the providers' professional status.

Long-Term-Care Benefits

As basic principles, the German LTC Insurance Act of 1994 states, first, that disease prevention and rehabilitation always should precede LTC and, second, that home care is preferable to institutional care. Thus, many of the LTC insurance benefits are designed to keep people who require LTC in their familiar surroundings, supported by relatives who will take over the care. The assistance is geared toward helping patients regain the ability to carry out routine activities of daily life independently.

TABLE 2
Monthly Benefit Rates ($U.S.)[a]

	Care level		
	I	II	III
Home care:			
Cash benefits to informal caregivers	227	455	739
Maximum monthly total for noncash benefits[b]	426	1,023	1,591[c]
Institutional care: maximum benefits	1,136	1,420	1,591[d]

[a]Average 1998 exchange rate: $1 = 1.76 DM.
[b]For example, fee-for-service payments to professional home health care agencies.
[c]For hardship cases up to $2,131 monthly.
[d]For hardship cases up to $1,875 monthly.
Source: Federal Ministry of Labor and Social Affairs 1998b.

Benefits fall into three categories: For home care, they are defined as follows:

1. cash benefits to informal caregivers, or
2. benefits-in-kind for the services of professional care providers, such as home health care agencies, and
3. for institutional care, cash payments to these facilities (table 2) (Bundesministerium für Arbeit und Sozialordnung 1998b).

Home Care

The following example illustrates the scope of benefits for the most intensive level of care rendered at home, namely level III. When relatives provide home care at this level, the cash benefits that compensate them for their work can be as much as $739 per month. In addition, the LTC insurance funds pay for other services, such as a special bed and modifications of the beneficiary's residence (e.g., to achieve wheelchair accessibility), which cost up to $2,841 per project. To improve the informal caregivers' quality of nursing care, the LTC insurance funds also provide free nursing-care courses. If the informal caregiver wants to go on holiday or is otherwise unable to care for the beneficiary, the LTC insurance funds pay for respite caregivers, or for part-time or short-term institutional care, for a period of up to four weeks a year. In such a case, the monthly cash benefits for informal respite caregivers also amount to $739 per month at care level III, or they may reach $1,591 per month if a professional

substitute is engaged. For a four-week stay in a part-time or short-term institutional care facility, the maximum payment is $1,591 per month.

In addition to these cash benefits, the informal caregivers receive payments into their own statutory pension insurance funds if they provide more than 14 hours of care per week. Thus, the LTC Insurance Act was designed to compensate for the fact that informal caregivers often have to give up their regular jobs or cut back on the number of hours they work in order to care for their relatives.

In case relatives cannot provide home care, the benefit recipient can choose noncash benefits. That means the member receives care from a home health or social service agency that employs professional care providers, including nurses. In that case, the LTC insurance funds will cover monthly costs up to $1,591 for care level III, and in special hardship cases, they will pay up to $2,131.

Institutional Care

If a member requires institutional care, the LTC insurance funds pay for basic care, social services, and treatment, again up to $1,591 per month at care level III, or in hardship cases, up to $1,875 per month. The recipients of care, or the public assistance system for patients below the poverty threshold, have to cover the costs for room and board as well as other services.

Given these payment criteria, the German LTC insurance benefits now cover about 50 percent of the average cost of institutional LTC. Even if a benefit recipient chooses a very inexpensive nursing home, the LTC benefits do not cover the total costs of nursing-home care. In fact, it is a program requirement that the recipient of care always pays at least 25 percent of the nursing home's rates.

All the benefits are also available to young disabled persons who require nursing care. Where recipients live in facilities that focus on integrating disabled persons into society instead of providing nursing care, the LTC insurance funds cover 10 percent of the institution's cost, or up to $284 monthly.

Cost Containment

Faced with this broad array of services, the demographic situation in Germany, and the steadily rising costs of social health insurance, the

government decided to set up several cost-containment provisions to preserve the financial stability of the social LTC insurance system. In principle, these provisions comprise (1) a careful definition of eligibility for LTC benefits; (2) a fixed range of benefits; and (3) a global cap on expenditures, in general, and limits on per person spending, in particular.

The most important component for cost containment is the "income-related expenditure policy," which, by law, ties the expenditures for publicly funded LTC strictly to the revenue and assets of the public LTC insurance funds. Overall spending is thereby not allowed to exceed revenue from members' contributions. Thus, the payers, that is, the associations of LTC insurance funds that negotiate and sign contracts with professional providers of LTC, are forced to negotiate fees that are within the funds' budgets. Contract disputes between providers and payers must be settled by arbitration.

Home Care

Home-care cost containment relies mainly on the income-related expenditure policy and the limit on per person spending. Thus, cash benefits for informal caregivers, on the one hand, and negotiated fees for bundled services delivered by professionals, on the other, cannot exceed the global budget of the LTC insurance funds derived from their members' contributions; and per person spending cannot exceed the limits set according to the different care levels. To enable their members to choose the most competitive home health-care agencies, LTC insurance funds have to provide regional service price lists of licensed suppliers to allow for comparisons.

Institutional Care

For institutional care, the government implements additional provisions. In order to avoid unwarranted "upgrading" of institutional care recipients, each LTC insurance fund is prohibited from spending more than $1,420 per month on average for each of their recipients of institutional care (i.e., care level II payment). If the total exceeds this level, the benefits for all institutional care recipients must be reduced, a contingency that would definitely encourage members to change their health insurance funds, and thereby their LTC insurance funds, which they are generally permitted to do once per year. To avoid the financial threat facing small

LTC insurance funds with a high number of institutional care recipients who are correctly assigned to care level III, such risk is shared among the seven associations of LTC insurance funds.

Quality Assurance

As LTC benefit provisions are increasingly subjected to cost containment, it becomes more important to adopt measures for assuring the quality of the benefits. To protect recipients from poor care, the government applied to the LTC insurance system most of the quality assurance principles that are also operative in the German health insurance system and introduced new provisions for monitoring the quality of LTC.

Responsibility for quality assurance of LTC belongs to the associations of LTC insurance funds as the main payers, on the one hand, and the associations of providers, on the other. By law, those partners have to agree on a framework for quality assurance, and all LTC providers are obliged to fulfill the quality requirements. In 1995, the responsible bodies passed an agreement that establishes standards for structural measures (e.g., staffing levels, educational requirements, building requirements), process measures (e.g., individualized planning and provision of care, documentation of care, inclusion of relatives), and outcome measures. In addition, the agreement covers procedures for auditing and decertifying LTC providers. The health insurance funds' medical service departments have assumed the added responsibility for auditing LTC providers.

In case a recipient receives home care solely from informal caregivers, the law states that the LTC insurance funds must train those caregivers in order to improve the quality of the care they provide. To receive second opinions, informal caregivers are visited by professional caregivers at least twice a year for care levels I and II and four times a year for care level III recipients. These visits allow for counseling and answering the questions of the informal caregivers. Moreover, the quality of care and the caregivers' capabilities are also assessed during the periodic home visits arranged by the health insurance fund's medical service department for the purpose of determining care-level assignments and providing regular follow-up. To inform their members and provide advice in case of problems with their care providers, some LTC insurance funds also have set up a special telephone hotline system for quality concerns.

The Long-Term-Care Insurance System in Operation: Preliminary Results

The German public and private LTC insurance funds have granted home-care benefits since April, 1995, and benefits for institutional care since July, 1996. Some of the results attained after about four years of operation are summarized below. (The first year was unrepresentative because of the benefit limitation and phased-in benefit payments.)

Benefit Recipients

In 1998, about 2.2 percent of the German population received benefits from their public (1.7 million) or private LTC insurance funds (.09 million). These 1.8 million benefit recipients who finally received approval for services represent roughly 75 percent of those members of the LTC insurance funds who applied for benefits. Not surprisingly, more than 80 percent of all recipients are older than 60 years. Nevertheless, this leaves about 300,000 recipients younger than 60 years who are served by the new type of social insurance.

When individual members apply and are approved for services, the individual can use the funds to pay for an informal or professional caregiver or for institutional care. As intended by the LTC insurance law, most recipients (72 percent) are cared for at home; only 28 percent live in institutions (e.g., nursing homes or homes for the disabled). Most of the recipients (89 percent of home care and 77 percent of institutional care recipients) fall into care levels I and II—having considerable or severe need for care (the remainder are in the care level III categories). Their care providers spend at least 90 minutes, but less than five hours, a day assisting with routine activities in the areas of personal hygiene, eating, mobility, and housekeeping. Thus, the system relies heavily on informal, home-based care providers, whom it attempts to provide with needed support.

Interestingly, of the total number of the recipients of care assigned to care level III, thus requiring round-the-clock help every day, more receive care at home (55 percent) than in institutions (45 percent). Thus, the new social LTC insurance system has actually achieved its goal of encouraging families to take care of relatives who require even the highest level of LTC within their familiar surroundings.

On the other hand, the fact that only 23 percent of recipients living in institutions are at level III is a concern because it was expected that such institutions would primarily be reserved for those with the greatest levels of disability. In part, this may be because all those individuals living in institutions prior to the enactment of the new program were allowed to remain in institutions if they chose to do so. Over time, it is expected that individuals entering institutions will have higher levels of care needs than those who remain at home. This development is promoted by the need criteria for institutional care that the LTC insurance funds agreed upon when the new program was initiated. Although individuals can freely opt either to go into an institution or to live at home, only those in need of LTC who are assigned to care level III can choose to enter a nursing home without any restraint. Individuals assigned to care level I or II who do not fulfill the criteria but choose to enter an institution (e.g., those who have no one to care for them, or whose relatives are unable to provide care or are overburdened with caring, or who lack other supports at home) only receive the payment that would have been permitted for professional home care. Therefore, individuals at care levels I and II have to bear a greater share of the cost of nursing-home care than those at care level III.

Benefit recipients, as well as caregivers, seem to be satisfied with the new law. A study by the University of Hamburg showed that about 80 percent of the home caregivers and recipients were satisfied with their situation after the LTC insurance system was implemented. About two-thirds of the caregivers and benefit recipients stated that the LTC insurance system encourages people to care for their relatives and that the system grants societal acknowledgment to people providing LTC (Runde, Giese, Kerschke-Risch, et al. 1997).

Long-Term-Care Expenditures

Because no data are available on the expenditures paid by private LTC insurance plans, we report here only on the public LTC insurance system expenditures that cover 95 percent of all benefit recipients. Of the $17.64 billion total expenditures in 1998, the public LTC insurance system paid $16.74 billion for benefits (table 3) (Bundesamt fuer Statistik 1999; Bundesministerium fuer Arbeit und Sozialordnung 1999). Although most recipients received benefits for home care, the proportion of institutional benefits to total expenditures within the social LTC

TABLE 3
Statutory Long-Term Care Insurance Expenditure Distribution in 1998[a]

Type of expenditure	Billion ($U.S.)	Percent of total
Main benefits:	14.81	83.9
Cash benefits to caregivers	4.76	27.0
Noncash benefits (care benefits-in-kind)	2.21	12.5
Full-time institutional care	7.84	44.4
Other benefits:	1.93	11.0
Holiday respite care	0.04	0.3
Part-time institutional care (day and night care)	0.04	0.3
Short-term institutional care	0.09	0.5
Social insurance contributions for caregivers	1.17	6.6
Nursing equipment (e.g. special beds)	0.37	2.1
Full-time institutional care in homes for the disabled	0.22	1.2
Program administration (including 50% of the costs of the health insurance fund's medical departments)[b]	0.90	5.1
Total expenditures	17.64	100

[a]Average 1998 exchange rate: $1 = 1.76 DM. Deviations in the sums are due to rounding errors.
[b]Health insurance's medical departments perform initial care-level assessments and regular follow-up visits; the second half of the costs are paid by the statutory health insurance funds.
Source: Federal Office of Statistics 1999; Bundesarbeitsblatt 1999.

insurance system amounted to 44 percent owing to the higher level of benefits provided to recipients in institutions (table 2). To cover a greater portion of the fixed costs of nursing-home care, the LTC insurance funds pay about five times as much for care level I recipients in institutions than for patients cared for at home ($227/$1,136). This ratio decreases to three times at care level II and two times at care level III ($739/$1,591). Because the average total costs for nursing-home care per month in 1996 were within the ranges of $1,879 to $2,352 for care level I recipients, $2,252 to $2,821 for care level II recipients, and $2,920 to $3,642 for care level III recipients, the LTC insurance benefits covered about 50 percent of the recipients' total costs, independent of their respective care level. The higher level of payments for institutional care could be an added incentive toward using the institutional benefits. Because individuals must pay at least a 25 percent share of cost (on average they pay about 50 percent) and because most individuals and families want to remain at home if at all possible, the higher payments for institutional

care have not appeared to cause any institutional bias, at least until now.

Within the array of home LTC benefits, cash benefits for informal caregivers ($4.76 billion) constituted the highest expense. The fact that unemployment was high in both East and West Germany may have resulted in heavier use cash benefits for informal caregivers than of benefits-in-kind to pay for formal service use. The acceptance of cash benefits may have had positive benefits in encouraging services to be provided at home rather than in nursing homes. The cash benefit did not appear to have had a negative impact (i.e., moral hazard) on the whole insurance program because the program has been able to keep within its projected financial budget. This may be because the program designed a lower payment rate for the cash benefits.

In fact, there is a slight trend toward purchasing formal services (i.e., benefits-in-kind) to provide care in the patient's home, which is more expensive than providing cash benefits. Whereas in 1996 the ratio of cash benefits to benefits-in-kind was 74 : 26, this ratio decreased to 68 : 32 in 1998. Within the benefit-in-kind system, the recipient of care purchases needed benefits from licensed home health-care agencies.

Because the reimbursement values of the benefits for the three different care levels that are provided within this system are about double the values attached to the respective informal cash benefits, the benefits-in-kind system is expected to assume an increasing share of total expenditures in the future. This effect will be further intensified if another trend continues, namely, the tendency to augment care by informal caregivers with additional professional help from home health-care agencies. On the other hand, if a recipient chooses professional, rather than unskilled, help in the home when appropriate, he or she may not be able to pay for all needed services within the allocated funds. Therefore, recipients have a financial incentive to avoid using unnecessary professional services so that they do not have to pay out of pocket. The effects on access and quality arising from the trends of using professionals and benefits-in-kind need to be studied.

Compared with cash and noncash benefits for home care and benefits for institutional care, the cost of all other benefits is minor. Only 3.4 percent of total expenditures was for part-time or short-term institutional care and holiday substitutes as well as caregivers' home rebuilding projects and nursing equipment. In addition, 6.6 percent ($1.17 billion) of total expenditures was spent to provide social insurance premiums for

informal caregivers, with the bulk going to pension insurance. This percentage is expected to decrease when more benefits-in-kind are used in the field of home LTC because professional care providers and their employers pay for pension insurance premiums directly, rather than using the LTC funds as the informal caregivers do.

Long-Term-Care Infrastructure

To address the rising need for home care services, the German government set up a program to promote the long-term-care infrastructure. From 1991 to 1998, the federal government spent altogether about $335 million for close to 400 different projects to fill existing gaps. In addition, the 16 states passed bills to promote investments in long-term care-facilities.

Therefore, access for persons who required long-term care has improved substantially during recent years, so much so that, in contrast to the limited access existing before the LTC insurance system went into effect, there is now an excess capacity in institutional care. The number of nursing homes increased from 4,300 in 1992 to about 8,000 in 1997. A large part of the increase was attributable to the conversion and recertification of former residential homes to qualified nursing homes. However, some regions in Germany still need more providers, especially part-time and short-term facilities. Home health-care services are provided by about 11,700 home health-care agencies, representing, to some extent, excess capacity. This number increased from about 4,000 in 1992.

The LTC insurance system has also had a dramatic impact on the labor market. About 70,000 new employment opportunities, especially for nurses, were attributable to the new insurance system within the first year of operation (April, 1995, to April, 1996). However, it is still uncertain whether the supply of workers will be adequate to meet the demands for LTC in the future. The initial training of informal and formal care-providers has apparently been sufficient to meet the current demand. Because of high unemployment rates, especially in eastern Germany, the supply of informal and formal caregivers has not been a problem under the current reimbursement system for LTC. Moreover, the heavy reliance on informal caregivers under the LTC program means that the demand for professional caregivers should remain within bounds.

TABLE 4
Financial Development of the Statutory LTC Insurance System and Number of Recipients of LTC during the First 4 Years[a]

	1995	1996	1997	1998
Revenues (billion $)[b]	10.0	13.83	17.67	17.78
Expenses (billion $)[c]	5.89	12.07	16.82	17.64
Annuals surplus (billion $)	4.12[d]	1.76	.86	.14
Accumulative surplus (billion $)	3.49	5.25	6.11	6.25
Beneficiaries (million)	71.9	72.3	71.7	71.5
Recipients of care (million)	1.06	1.55	1.66	1.72
Percent home care/institutional care	100/-	75/25	73/27	72/28

[a]Average 1998 exchange rate: $1 = 1.76 DM.
[b]Premiums have been 1.0% of gross income for the period from January 1, 1995 to June 30, 1996, and 1.7% after July 1, 1996.
[c]Since July 1, 1996, institutional care benefits have been added to the provision of home care benefits; expenses do not include federal and state investment programs relating to LTC infrastructure.
[d]In 1995: 12 months' contribution payments, but only 9 months' provision of benefits only for home care. Of that, $.625 billion was granted as a long-term loan to the Federal Government.
Source: Federal Office of Statistics 1998, 1999; Bundesministerium fuer Arbeit und Sozialordnung 1999.

Financial Status of the System

After three years of full operation, preceded by one year of partial operation, the new system shows financial stability (table 4) (Bundesamt fuer Statistik 1998; 1999; Bundesministerium fuer Arbeit und Sozialordnung 1999).

During the first four years of operation, the nonprofit, social LTC insurance funds accumulated a surplus of more than $6 billion as a result of the statutory requirement that contributions to the system had to be made three months before benefits commenced. The principal purpose of this start-up funding was to create within each LTC insurance fund a surplus that could absorb at least 1.5 months' worth of expenditures. The reserve requirement was exceeded, resulting in the surplus, which was made available to the federal government to enable it to grant loans for program-related investments in the economically weak eastern states. The current cumulative surplus remains at a level that the government considers adequate to respond to any unexpected demands on the system.

In 1995, only home care benefits were provided. Starting in July, 1996, the entire array of services became available: cash benefits to informal caregivers, benefits-in-kind for the services of professional home health-care providers, and benefits for institutional long-term care. Expenditures in 1998 per care recipient in the social LTC insurance system came to about $10,300 for 1998. The 71.5 million beneficiaries of the statutory LTC insurance funds encompassed 21 million covered as family members, who pay no premiums, and about 51 million contributing members. Thus, the contributing members paid on average $348 per year to finance the system, whereas the cost per beneficiary was $247.

Issues

During the first years of operation, the new social and private LTC insurance system of Germany achieved most of its goals: Persons in need of LTC services now are entitled to benefits that primarily support receipt of care in their homes. Informal caregivers receive recognition for the burden of caring for their relatives by being paid cash benefits and pension insurance contributions from the LTC insurance funds. In case a German family cannot care for a relative who needs LTC, the system pays for professional care providers' services or for a portion of the costs of nursing-home care. To strengthen this part of the LTC infrastructure, the federal government and the states supported investments, particularly in short-term or part-time nursing facilities. For professional LTC, the law assures the quality of care by obliging all providers to meet quality standards and enforcing those standards through regular audits. Cost shifting from the social assistance system to the new LTC insurance system lightened the financial burden on the communities for long-term-care payments by $4.5 billion per year (Bundesamt fuer Statistik 2000). So far, the LTC insurance system is financially stable.

Yet, as was to be expected for an LTC insurance system that introduced uncharted major dimensions to the system of comprehensive social insurance, some areas still require careful observation.

Quality of Long-Term Care

The system has been criticized for how it provides home care benefits. Critics claim that the system mainly pays for services that family members

would have provided anyway in the absence of LTC benefits, and that the informal familial caregiver accepts insurance payments because their relatives are entitled to them. Thus, the way LTC is provided is not altered by the payment arrangements (Klie 1998). The critics find fault with perpetuating traditional family arrangements and question the quality of care in the informal caregiver setting. Interestingly, the system that has been recently proposed in Japan, where the daughter-in-law has traditionally been the primary caregiver for the elderly, does not include cash benefits for caregiving family members, but instead limits itself to the purchase of professional LTC services (Ikegami 1997).

To answer those criticisms, the associations of providers and LTC insurance funds argued that for the first time—by means of the LTC insurance system—there are opportunities to improve quality by supervising and counseling families who care for their relatives. Because informal caregivers receive regular visits and advice from professional care providers and are also granted free training courses, the quality of the care they provide should improve. To finance these training courses for informal caregivers, the LTC insurance funds spent about $11 million in 1997. In addition, more families are combining part-time professional care providers with informal LTC in the home, thereby improving the overall quality of care.

However, because studies that evaluate the outcomes of LTC in the three different arrangements—home care by informal or by professional caregivers and institutional care—have yet to be conducted, there is no objective way to know whether the care being provided is adequate or whether some arrangements might achieve superior results. Such a study conducted over time would be especially important to ensure that the quality of care is not jeopardized by the overall spending cap imposed on the LTC insurance funds. Study results could be used to avoid rationing by providing the rationale for shifting the provision of care to the most efficient providers. The findings could also provide the justification for eventually increasing revenues of the LTC insurance funds by raising the amount that members contribute, if necessary.

Another criticism refers to the provision of preventive and rehabilitative services, as well as nursing equipment, within the home care setting. Until now, few of the recommendations for rehabilitative services that were made during home visits by physicians and nurses of the health insurance funds' medical departments have been put into practice (Lucke, Messner, and Lucke 1997). Because rehabilitation is a task of the health

insurance funds, they are currently working on guidelines to improve rehabilitative services and to facilitate cooperation with LTC insurance funds and primary care physicians.

Fraud and Abuse

An important feature of the German LTC Insurance Act is that neither the federal or state governments nor the payers can restrict the number of providers. The regulation prohibiting this restriction was intended to encourage the creation of new services and to promote competition between the different for-profit and non-profit suppliers of LTC services. However, by tolerating the creation of excess capacity, the risk of systemic fraud and abuse and of incurring higher expenditures may be intensified. Recently, considerable media attention was devoted to the home health-care agencies in Hamburg, which has the country's highest excess capacity. There were fraud prosecutions against 60 of 413 home health-care agencies in that city. Some LTC providers who were providing substandard care have already lost their licenses. However, it appears that, in most cases, the reason for prosecution was not related to quality problems or false billing, but rather to alleged embezzlement of tax payments or social insurance contributions for the agencies' employees.

In response to these incidents, the LTC insurance funds have agreed to scrutinize carefully the mandatory documentation of services and fees provided by the home health-care agencies to the insurance funds. Whether the LTC Insurance Act will be changed in the future to avoid excess capacity is still being debated. Meanwhile, the LTC insurance funds argue that new regulations against fraud and abuse are not yet necessary.

Staffing Levels

Another line of criticism refers to the impact of the LTC Insurance Act, especially its cost-containment provisions, on the staffing levels in nursing homes. The level of staffing in German nursing homes has been reported to lag behind that of the United Kingdom and the United States (Alber 1992). Moreover, the level of staff training is a matter of concern because, on average, only 35 percent are skilled nurses. In 1993, prior to enactment of the LTC insurance plan, the federal government

passed a bill that would raise the level of skilled staff in nursing homes to at least 50 percent of the total staff in 1998. However, the effective date of this regulation has been postponed to allow nursing homes to adjust to the new requirements of the LTC insurance system. Therefore, critics claim that the new LTC insurance system, instead of exerting its financial power to put new knowledge of gerontology and nursing science into practice, has allowed the low quality of nursing-home care in Germany to persist, thereby increasing the workload and frustration of nursing-home staff (Graber-Dünow 1998).

One of the main tasks of the Federal LTC Committee is to heed these criticisms and find solutions for reported problems. Because a comparable group, the Committee for Concerted Action in the Health Care System, is already functioning successfully in the field of health care, the federal government assumes that the various stakeholders in the LTC insurance system will be able to negotiate their competing interests successfully without major conflicts.

Financial Projections

Because different cost-containment mechanisms have been in place since the LTC program began, future spending for LTC in Germany is expected to remain within the budgets of the LTC insurance funds. The program's declining surplus margin does not seem to be the harbinger of financial imbalance because financial stability is assured in a number of ways:

1. equalization between profitable and unprofitable LTC insurance funds
2. the cap on per recipient spending
3. the ability to adjust the benefits
4. the gradual increase in the contribution rates required by statute

Nevertheless, the future development of the system depends upon its financial projections. The Federal Ministry of Labor and Social Affairs estimates that an additional 330,000 people will need LTC by the year 2010. To meet the future demand imposed by population growth, the Federal Ministry expects that the aggregate shared employer–employee contributions will have to be increased gradually, from 1.7 percent to 2.4 percent of the gross employee income by 2030.

Whether employers and employees will continue to divide equally the 2.4 percent contribution 30 years from now, or whether the employers' portion will be fixed at the current level of 0.85 percent, is already a matter of discussion. German business will certainly oppose any increase of its social insurance burden. Underscoring further the fluid nature of the whole concept of contributions for social insurance, the new Social Democratic federal government is currently discussing ways to reduce social insurance contributions across the board. Pension insurance contributions have already been reduced from 20.3 percent to 19.5 percent of the employees' gross income in 1999.

All considered, with the cost-containment measures that have been discussed here in place, combined with an even broader basis of revenues for the LTC insurance funds, the government expects the public LTC insurance system to be stable for at least the next 30 years.

Conclusion

In view of the promising start of the new LTC insurance system in Germany, U.S. policy makers who weigh the feasibility of devising a social insurance approach for LTC and debate its possible shape and practicality can obviously profit from observing the reported German experience. The trade-off between financial stability and cost containment on the one hand, and coverage for an appropriate array of LTC services in an environment of rising LTC needs on the other, must be carefully watched to ensure the long-term success of the system.

Regardless of the balancing that will be required in the decades to come, the addition of the important LTC dimension to the German system of social security has provided a relative freedom from financial anxiety for all segments of the community and can be seen as a clear gain for society. As such, it merits our close examination.

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